

PHYSICIAN ORDER
for Life-Sustaining Treatment

This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If in the clinical record, this should be first page. In other setting, locate in a prominent place. When need occurs, first follow these orders, then contact the physician.

Last Name of Patient/Resident

First Name/Middle Initial

Date of Birth

Any Section not completed indicates all treatment in that Section will be provided.

SECTION A CHECK ONE BOX	Treatment options when the patient / resident has no pulse and is not breathing. _____ Resuscitate _____ Do Not Attempt or continue any Resuscitation (DNR)																	
SECTION B CHECK ONE BOX ONLY	Treatment options when the patient / resident has pulse and is breathing. _____ Comfort Measures only. Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, warmth, and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. <u>Transfer only if comfort measures fail.</u> _____ Limited Additional Interventions. Includes care above. May include oxygen, suction, treatment of airway obstruction, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids. Transfer to hospital if indicated, but no endotracheal intubation or long term life support measures. Usually no intensive care. _____ Full Treatment. Includes all care above plus endotracheal intubation and cardioversion. For Hospitalization: Transfer only if necessary to: _____																	
SECTION C CHECK ONE BOX ONLY	ANTIBIOTICS. Comfort measures are always provided. _____ No Antibiotics except if needed for comfort. _____ Oral Antibiotics _____ Invasive (IM/IV) antibiotics Other Instructions:																	
SECTION D CHECK ONE BOX ONLY	ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITIONS. Comfort Measures are always provided. _____ No Feeding tube _____ No IV fluids _____ Defined Trial period of feeding tube/IV Fluids. _____ Long-term feeding tube/IV Fluids. Other Instructions:																	
SECTION E	<table border="0" style="width:100%"> <tr> <td style="width:50%">Discussed with:</td> <td style="width:50%">Summarize Medical Condition:</td> </tr> <tr> <td>_____ Patient/Resident</td> <td></td> </tr> <tr> <td>_____ Parent of Minor</td> <td></td> </tr> <tr> <td>_____ Health Care Agent</td> <td></td> </tr> <tr> <td>_____ Court-Appointed Guardian</td> <td></td> </tr> <tr> <td>_____ Spouse</td> <td></td> </tr> <tr> <td>_____ Other</td> <td></td> </tr> <tr> <td colspan="2">Name of Health Care Agent and Phone Number:</td> </tr> </table>		Discussed with:	Summarize Medical Condition:	_____ Patient/Resident		_____ Parent of Minor		_____ Health Care Agent		_____ Court-Appointed Guardian		_____ Spouse		_____ Other		Name of Health Care Agent and Phone Number:	
Discussed with:	Summarize Medical Condition:																	
_____ Patient/Resident																		
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_____ Spouse																		
_____ Other																		
Name of Health Care Agent and Phone Number:																		
Signature of Patient/Resident, Guardian , Health Care Agent	Print Name and Phone Number	Date																
Signature of Physician (Mandatory)	Print Name and Phone Number	Date and Time Signed																
ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT ON TRANSFER OR DISCHARGE																		

How To Change “Physicians Orders for Life Sustaining Treatment”

This form, Physician’s Orders for Life-Sustaining Treatment, should be reviewed if:

1. The patient/ resident is transferred from one care setting to another;
2. There is substantial permanent change in patient/resident health status; or
3. The patient/resident treatment preferences change.

Review Patient/Resident Preferences as a Guide for Physician Order for Life-Sustaining Treatment (Section F). Record the review in Review of Physician’s Orders for Life-Sustaining Treatment (Section G).

To Void this FORM, draw a line through the Physician’s Order and/or write the word “VOID” – Sign and initial the form. IF NO FORM IS COMPLETED, FULL TREATMENT MAY BE PROVIDED.

SECTION Patient/Resident Preferences as a Guide for Physician Order F for Life Sustaining-Treatment

I have given significant thought to life-sustaining treatment. The following have further information regarding my preferences:

Advanced Directive _____ NO _____ YES

Court-Appointed Guardian _____ NO _____ YES

Power or Attorney for Health Care _____ NO _____ YES

I expressed my preference to my physician and/or health care provider(s) and agree with the treatment order on this document. Please review these orders if there is a substantial permanent change in my health status such as:

Close to Death Advanced Progressive illness Improved Condition
Permanently unconscious Extraordinary Suffering Surgical Procedures.

Signature of Person Preparing the Form	Preparer Name (type or print)	Time and Date Prepared
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SECTION REVIEW OF PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT G

Date of Review	Reviewer	Location of Review	Outcome of Review
			___ No change ___ Changed, FORM VOIDED ___ Changed, NEW FORM
			___ No change ___ Changed, FORM VOIDED ___ Changed, NEW FORM
			___ No change ___ Changed, FORM VOIDED ___ Changed, NEW FORM